

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Wednesday, January 16, 2002
9:34 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item:
Public Comment 2

MR. CHINCHINAO: Thank you. I'm Dolph Chinchinao, representing the National Kidney Foundation. We wish to thank the Commissioners for their recommendation for a dialysis rate update and use this opportunity to highlight some of the changes in the demographics of the dialysis population since the composite rate was introduced in 1983.

In 1984, 7 percent of the dialysis population was over 75 years of age. In 1999, that had doubled to 14 percent of the prevalent ESRD population over 75 years of age. And that segment continues to be the fastest growing part of the population.

Secondly, the percentage of patients who came to dialysis in 1984 because of diabetes as the primary cause of kidney failure was about 16 percent. By 1999 that also had doubled to 33 percent. We are convinced that the recommended update will ensure that these older and sicker patients receive the kind of services that they need.

Thanks again.

MS. NAZACK: I'm Susan Paul Nazack with the American Association of Homes and Services for the Aging. We represent the non-profit continuum of long-term care that includes nursing homes, skilled nursing homes, both hospital-based and freestanding.

We applaud the fact that there is a recommendation to keep what I'll call the Z again, in the base because we certainly do need to keep the money there. However, the concern with the access for medically complex residents. These are people who have a variety of different cases. They have non-therapy ancillary costs that far exceed the average payment. If we only provide additional monies to the hospital-based, then the freestanding that are also taking care of the medically complex patients are going to be at a tremendous disadvantage and could really hurt access.

Virtually all SNFs serve some medically complex patients. However, the residents who utilize non-therapy ancillary costs that greatly exceed the payment can be found probably in all RUG groups, but they have a great probability in being in the RUG groups for the extensive services. It is not unusual to have non-therapy ancillary costs of \$700 a day. This is for skilled nursing facilities that are freestanding, as well as the hospital-based.

Patients categorized in the extensive services have IV medication, suctioning, tracheotomy, ventilation service, IV feeding. These people are very sick and they need to have services.

The access problems that have been identified in the past, though they've not been totally identified, are primarily these type of patients and these are the ones that are going to be

having even harder services if the freestanding do not get an added amount that could help compensate.

Thank you.

MR. LANE: Larry Lane, Genesis Health Ventures.

A couple of points. Pete asked, in some sense, what are we talking about in magnitude? X is about \$500 million. Y is about \$0.9 billion or about \$900 million. Z is about \$1.2 billion for a total component of \$2.6 billion. The market basket change proposed is about \$400 million.

The Commission recommendation discussed today takes \$1.8 billion out of the skilled nursing sector. And the real question the Commission has to address is can that sector absorb that impact? It translates, if I heard Sally correctly, the minus 2 percent margin, this translates into a margin impact negatively of approximately 4 to 5 percent.

The question really begins to be if you throw the anchor into the middle of the boat rather than in the water, who is going to take care of mama?

The margin analysis must say must be done in the context of admission discharge was not discussed that way and we've given staff an analysis done using CMS claims file analysis that tracks admission and discharges '94 through 2000. And it will point out very simply that there's 100,000 fewer beneficiaries served in '99 than '98 by skilled nursing facilities. It also points out that approximately 82 percent of the admissions and discharges are in the freestanding side. So a lot of attention is being given to the hospital-based component.

The third is is that hospital-based component different? And I will add to materials I have given staff a study that we've just gotten today from Curry Kilpatrick out of the University of North Carolina, and Bill Roper was engaged in this. I'd just read two points in the total regression analysis that they did.

One, our analysis showed no substantial differences in the capability to the level of care that is offered by freestanding versus hospital-based SNFs.

Two, we found no evidence to support that the PPS or BBRA had a differential effect on hospital-based facility compared to freestanding SNFs.

I must say while APR DRGs is a novel idea, it is not the basis for the payment structure that is in place today in the case-mix index. And when hospital-based versus freestanding are analyzed using that index, what comes up is it is not the setting that is the difference. The real question is are we going to redo what was old policy? That was reward hospitals for their inefficiency. Or are we attempting to try to drive an efficient care delivery structure.

Thank you and we'll continue to talk with you, I guess, over the next coming weeks.

MS. FISHER: Thank you. Karen Fisher with the Association of American Medical Colleges.

I want to take us back, I apologize, to hospitals. We appreciate the fact that it seemed this morning that the Commissions thought that total margins would be a useful piece of information to have when looking at updates in financial performance. Given that, I think it might have been helpful in this afternoon's discussion if total margins were part of that discussion. Unfortunately, they weren't.

If you look at the total margins that Craig presented, unfortunately I don't think it was not presented today total margins for large urban hospitals. But let's, for the moment, assume somewhat of a proxy with major teaching hospitals. If we assume that what was presented for major teaching was 2.4 percent, then if you look at the analyses by the staff of taking the 1998 overall Medicare margin and the staff doing its best efforts to increase that to 2002, there's obviously a decrease in overall Medicare margins between those three years by 2 percentage points, 2.1 percentage points.

Assuming private payers' behavior remains the same, that's going to mean a reduction in the total margins for those institutions that could be almost up to 1 percentage point.

You then factor in the fact that for these institutions you're not going to give a full market basket update but market basket minus 0.55 percent, you start to bring the total margins for these institutions possibly dangerously close down to one. And that's assuming private payer behavior stays the same.

I would hope that given the Commission's discussion this morning about the value of total margins that the estimates that are used for Medicare, et cetera, can be expanded to total margins and at least brought forth for the Commission to have that discussion and have that information before them when they make their decisions.

Thank you.

MR. PYLES: My name is Jim Pyles. I'm here on behalf of the American Association for Home Care.

I just wanted to commend the Commission for the recommendations, all three recommendations with respect to home health. The recommendation particularly with respect to the elimination of the 15 percent cut, I think finally puts home health on the path to a rational reimbursement system and one that can be refined in the future to meet the clinical needs of the patient.

I would just ask you though, as you go forward with further deliberations on home health, to remember there were 1 million Medicare beneficiaries eliminated from the home health benefit over a two year period. That's a fourth of the beneficiary population. We know from GAO studies and from MedPAC analyses that the greatest reductions were among the highest utilizers in the patients in the rural areas. We believe those are the most vulnerable patients. We believe there has to be and is an access problem among those patients who cannot have that degree of

reduction or elimination of patients from a benefit without their being an access issue. And we know that there are many rural areas across the country that are either down to their only home health agency left or they've lost the one home health agency they had.

We hope in the future that you'll look at home health not in isolation to determine whether it's growing too fast or too slowly, but to look at it as a tool for addressing the need to provide more services for less dollars.

Thanks very much.

AUDIENCE SPEAKER: I'll obey the rules and I won't repeat everything that my colleagues in long-term care have said before, in Larry Lane and Susan Paul Nazack.

But I would plead with you to pay special attention to some of the points that Susan made because I think there is a very critical issue here. That is do you believe that there is an access problem for skilled nursing facilities? Or do you believe there is not an access problem for SNFs?

Today Commissioner Reischauer said the following: Preservation of facilities should not be an objective unless preserving access. If there is no access problem then it is difficult to follow the logic of distinguishing between the hospital-based SNFs and the freestanding SNFs. But if there is an access problem, and we have believed for a long time, with the American Association of Homes and Services for the Aging that there may indeed be an access problem for the very, very acute patient, the patient with very high acuity.

And therefore, the important thing is to get that patient both into a hospital-based SNF and into freestanding SNFs. Because that patient may actually be backing up in the acute part of the hospital itself.

So I would ask that you, if possible, revisit the issue of the freestanding versus the hospital-based SNF. Along those lines, you might even ask, as Commissioner Raphael did, what are the basis of those hospital costs that make them so high in the hospital-based SNF? They can't possibly be entirely due to the issue of acuity.

And last but not least, the question about the product. I won't question that perhaps the length of stay is about half, and perhaps there are more RNs, but where does the hospital-based patient go when he or she leaves the hospital-based SNF? Is it to hospital-based home health care? Is it to home health care period? Or is it to freestanding SNFs?

We do not have the data but if memory serves me correctly, I think even MedPAC a couple of years ago looked at that issue. You might try to find that data and see if indeed quite a few of those patients crossover to freestanding SNFs.

Thank you.

MR. HACKBARTH: Okay, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:22 p.m., the meeting was recessed, to reconvene at 8:30 a.m., Thursday, January 17, 2002.]